

Referral for minor mental illness: a qualitative study

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SUMMARY

Background: Mild depression and anxiety are common problems in general practice. They can be managed by the general practitioner (GP) alone or referred. Previous quantitative studies have shown a large variation between GPs in terms of referral behaviour. The reasons for this variation are not fully understood.

Aim: To describe and analyse GPs' decision-making processes when considering who should be treating patients with minor mental illness, using a qualitative method.

Design of study: A qualitative interview study.

Setting: Twenty-three GPs in east London and Essex.

Method: Subjects were chosen using a purposive sampling strategy and participated in one-to-one semi-structured interviews. A grounded theory approach was used for analysis.

Results: Two distinct referral strategies were identified — the 'containment' and the 'conduit' approaches. In addition, referrals were found to be of two types — proactive 'referrals to' and reactive 'referrals away'; for minor mental illness the 'referrals away' were found to predominate. Emotive as well as rational responses informed GP decision making on referral.

Conclusions: Explanations of the variation in referral rates need to recognise the emotive responses of individual GPs to minor mental illness. The contribution of guidelines, which assume consistently rational responses to illness, may therefore be limited.

Keywords: depression; anxiety; mental illness; referral behaviour.

Introduction

DEPRESSION and anxiety are common diagnoses in general practice.^{1,2} Patients experience a great deal of suffering and use of primary care services is high. The costs to the individual, their relatives, the health service, and to society in general in terms of working days lost is also high. The financial cost has been estimated at £3.5 billion per year.³ Patients who are recognised by their doctor as having mild depression or anxiety may be managed by the general practitioner (GP) alone, or referred to a paramedical health professional (for example, a clinical psychologist, community psychiatric nurse or counsellor) or be referred to a psychiatrist. Previous studies have shown a large variation between GPs in terms of referrals made to mental health services⁴ and to secondary care in general.⁵ The high morbidity and financial costs of this type of problem make appropriate management important. To inform future decisions regarding commissioning policy, and if guidelines are to be developed and implemented, it is important to take into account what currently makes a GP decide to refer a patient with a minor mental illness.

Most work trying to understand GP referral behaviour has used quantitative methods to explain variation in referral rates. In more recent studies, qualitative methods have been used to develop a framework for analysing referral decisions⁶ and also to explore the role of patients as collaborators in the process of primary care referral for psychological problems.⁷ In this study, we sought to add to the understanding of referral behaviour by describing and analysing GPs' decision-making processes when considering who should be treating this particular group of patients.

Method

Design and setting

We conducted one-to-one semi-structured interviews with 23 GPs in east London and Essex. Responders were selected from Health Authority lists in Hackney and Waltham Forest, a database of GPs working in the Barking and Havering district and two GPs who were known professionally to the authors in Tower Hamlets. Purposive sampling⁸ was used to select a maximum variety of GPs in terms of age, sex, country of undergraduate training, employment status (whether principal, assistant or locum), area of practice (inner London, outer London, Essex) and interest in mental health. This strategy allowed a range of opinions and perceptions to be gathered.

Data collection and analysis

Most GPs were contacted originally by letter and then telephoned to ask if they were willing to participate. The interviews were conducted by two GPs (CCW, SN) and involved

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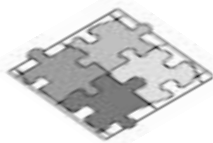
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Submitted: 3 May 2000; Editor's response: 24 August 2000; final acceptance: 2 November 2000.

©British Journal of General Practice, 2001, 51, 461-465.

HOW THIS FITS IN*What do we know?*

Mild depression and anxiety are common problems in general practice. GPs have a choice about whether to manage these patients themselves, or to refer them to other workers. There is a large variation between GPs in terms of referral behaviour.

*What does this paper add?*

The 'containment' and 'conduit' referral strategies were identified. In addition referrals were found to be of two types — reactive 'referrals away' (particularly prominent in the management of minor mental illness) and proactive 'referrals to'. These 'referrals away' often have a significant emotional component on the part of the GP.

asking open-ended questions about the responders' management of minor mental illness. Minor mental illness was defined as 'the mild depression and/or anxiety which is commonly seen in general practice, and may reasonably be dealt with by a GP alone or be referred on'. The interviews were audiotape-recorded and transcribed; anonymity was emphasised. A grounded theory⁹ approach was used to analyse the data by generating explanatory concepts and categories. This was done in conjunction with 'framework',¹⁰ a systematic practical method of managing, structuring, and analysing the data. The process was iterative in that the initial analysis began after only a few interviews, allowing emerging categories and concepts to be probed in the later interviews. By the twenty-third interview it was felt that no new concepts were being generated ('saturation').⁹ The analytical framework was developed by a multi-disciplinary team (including doctors and social scientists) to increase the reliability of the study.¹¹

The results were presented to a group of 12 GPs just before completion of the analysis. This was to help assess field validity, confirming that the categories and concepts concurred with these doctors' experience and that no dissonance with their practice was felt.

Results

The interviews were conducted between December 1998 and August 1999. Of the 34 GPs approached, 23 agreed to be interviewed. Their mean age was 44 years (range = 30–61 years). Eight were women, 20 were principals, one was an assistant, and two were full or part-time locums (see Table 1). The recording quality of two of the interviews was too poor to be transcribed; for these, field notes were used to contribute to the analysis.

A large dataset was obtained, including information about diagnosis and definitions of minor mental illness, the value of counselling services, and the medicalisation of minor mental illness. The analysis was concentrated on two major categories that were generated regarding referral — 'conduits'/'containers' and 'referrals to'/'referrals away' — and the concept of the role of emotive responses in referral. These are described and accompanied by illustrative data in the form of quotes (GPs designated by a number were interviewed by CCW, those with letters by SN).

Category 1: 'conduits' and 'containers'

The analysis generated two distinct referral strategies: the 'containment' and the 'conduit' approaches. Containment was adopted by GPs who tended to see minor mental illness as part of the remit of general practice and their role partly to prevent what they regarded as an inappropriate burden on other agencies.

'I've managed quite a lot myself... Most people don't want to be referred ... people still want that personal contact with their GP.' (GP A.)

On the other hand, those GPs who adopted a conduit strategy saw themselves more in a diagnostic, and then triage, role and felt that these patients are best managed by others.

'I'm sure that the GP's job is access. The NHS is set up so it's difficult for people to get to secondary care, that's how the NHS works. My job is definitely to facilitate access to appropriate services for patients.' (GP 5.)

Of course GPs did not necessarily and simply fall into being either a conduit or a container. Many used both strategies, and there was a continuum of behaviour. We explored the features of containers and conduits in an attempt to uncover what it was that caused one type of behaviour or the other. Some GPs felt very strongly that minor mental illness should be contained within general practice and that as soon as it is not contained it ceases to be minor. Others felt that the GP's job is managing access to other services and that for reasons of lack of time or expertise they were not the best people to be dealing with these problems.

'When I first started in practice I would occasionally see people outside surgery hours, give them an hour, but that sort of time that people need I can't do that and therefore I now find it's better to refer them on to someone else who can be seeing them for an hour a week on a regular basis. I can't give that sort of time to people.' (GP E.)

However, the majority of GPs described an approach whereby they would initially see the patients themselves for a period and then refer sometimes.

'If we are going round and round in circles and not making any headway, that's when I refer the patient.' (GP C.)

'I would refer... If I felt I was getting out of my depth.' (GP 6.)

Reasons for referral included lack of progress and poor rapport with the patient, often accompanied by feelings of frustration, irritation or anger. Containment behaviour was enhanced by interest in minor mental illness and by confidence in dealing with particular mental health problems. Thus both the individual features of the GP (e.g. training, interest) and developing factors (e.g. a perception of inadequate time or failure of progression, often engendering emotive

Table 1. Characteristics of interviewed participants.

Characteristic	GPs interviewed (n = 23)	GPs who declined to be interviewed (n = 11)
Age (years)		N/K
30–39	7	
40–49	9	
50–59	6	
>59	1	
Sex		
Male	15	9
Female	8	2
Employment status		
GP Principal (partner)	18	6
GP Principal (single-handed)	2	5
GP Assistant	1	0
GP Locum	2	0
Country of undergraduate training		N/K
UK	14	
India	7	
South Africa	1	
Australia	1	
Area of practice		
Inner London	14	5
Outer London	2	2
Essex	7	4

N/K = not known.

responses in the GP) contributed to whether a GP exhibited conduit or container behaviour. Some specifically mentioned that when they referred a patient they still wanted to be actively involved in the management of the patient, i.e. mixed conduit and container behaviour. As this model was emerging, GPs in the later interviews were asked if they could identify with these strategies and if they felt they were one or the other; most said they were both but leant towards either the conduit or container approach.

'I'm by and large the latter — I try and contain.' (GP L.)

Some GPs mentioned that their management of minor mental illness was enhanced by a good supporting structure (e.g. ability to talk with other partners, local sources of expert advice) or more formal supervision of the GPs, but it was not clear from the data whether these enhanced container behaviour. However, one GP did feel that containment of patients often worked at the practice level rather than containment by an individual doctor.

'I think that people with minor mental illness are probably contained by the practice as much as they are by individual doctors or nurses within the practice. I think by virtue of the practice just being there. I think it's an important way that mental health distress is coped with.' (GP 1.)

Category 2: 'referrals to'/'referrals away'

GPs' reasons for referral were of two kinds:

1. For 'proactive' reasons; for example, the particular skills that a worker such as a counsellor has to offer or

because a patient has a desire to be referred. These could be described as 'referrals to' other professionals.

2. For 'reactive' reasons; for example, after failure of GP management or because the GP could not give patients the necessary time. These can also be looked at as 'referrals away' from the GP. Most referrals were for reactive reasons.

'Referrals to'. These were often for very specific situations (e.g. drug or alcohol addiction, ethnic groups where counsellors who spoke the patient's first language were available, treatment for phobias/panic disorders) or when a GP thought that a particular patient would benefit more than average from referral, with respect to potential for long-lasting change. Another reason was patient choice, either by request or after being given options for treatment. There was a strong feeling among these GPs that most patients would obtain additional benefits from referral compared with management by the GP alone.

'Many people need this [referral to a psychiatrist]. Somehow that process is needed. I've discussed it with my registrar in tutorials and we call it sort of touching — not touching God but touching sort of — the top of the mountain; the patient sometimes needs that even though you know that nothing particularly different will happen.' (GP A.)

'I realised that counselling is a great skill ... and I realised that actually I don't think I'm the world's best at it ... The reason I refer people to counsellors is so that patients are given an opportunity to understand themselves better and to grow as people, that the process is a maturing process and that hopefully as well they'll finish the counselling process with a series of tools that will help them in their lives for the future.' (GP F.)

'I find our counsellor particularly useful for patients where they need to make a change in their life... I often refer people if there are environmental factors that have potential for change.' (GP E.)

'Referrals away'

The 'referrals away' were often triggered by certain emotions on the doctor's part. Feelings of frustration, anger, and irritation were viewed as warning signs that the GP needed help, rather than an active decision that referral would be good for the patient.

'[A discussion about referral would be precipitated] if I feel I'm not getting very far with them and they've come on a number of occasions and I feel that they're not mentally forming an interaction with me alone or they feel they need something more, and unfortunately it sometimes can become a dumping ground because I think I've seen this patient for a long time.' (GP 2.)

'a bit of bloody relief.' (GP 1.) [in reply to: 'What do you expect from referral?']

'I don't think that I could personally cope with it...I'd just be too worn out [if not able to refer some patients].' (GP 6.)

Other reasons for the negative 'referrals away' included lack of time, failure of GP management (as with patients who are initially contained and then referred when not improving) and instances when it was felt that patients would not want to talk about such personal details with someone they knew well.

'Before counsellors started to appear on the scene I used to do a lot of that work ... Such a workload is actually very difficult to maintain.' (GP F.)

'Some patients want to keep some separation ... if they're referred to a psychologist or a counsellor, what goes on there is something I don't have to know everything about.' (GP A.)

'... because of time or of my knowing the patient so well that they're not going to open up fully then I refer them to see the counsellor.' (GP C.)

The role of emotive responses in referral

For those GPs that initially contained but then referred after a period of management by themselves only, the role of feelings as a trigger for referral was often prominent. GPs would use their own feelings (e.g. frustration or irritation) as a gauge that progress was not being made or that they were not the right person to be dealing with this patient. One GP even spoke of feelings of contempt sometimes acting as a warning sign for him that referral was necessary.

'If you find yourself being too contemptuous of a patient it's rather dangerous ... sort of red warning light that says "come on you shouldn't be doing this, someone else should be doing it".' (GP 1.)

Similarly, when looking at the second category, a major difference between the two types of referral was that the 'referrals to' tended to be thought out, intellectual decisions, whereas 'referrals away' had a much higher instinctive or emotional element to them. We have conceptualised this as the difference between rational and emotive decisions. It was noticeable how dominant the emotive reasons were over the rational.

Discussion

Methodological issues

This study was designed to explore GPs' decision-making processes with respect to referral for minor depression/anxiety. Previous quantitative work has shown that GPs vary in their practices.^{3,4} This study chose a qualitative method to explore how and why GPs make their decisions in order to throw some light on this variation. The methods used were chosen to increase the rigour of the study. It was felt that use of a maximum variety sampling technique (i.e. obtaining a broad range of GP types) would increase the validity of the

study. However, it did concern us that those GPs who declined to take part may have had different referral strategies to those that agreed. For example, single-handed GPs, who may have different work patterns and be professionally isolated, were over-represented in the group that declined. A future study with funding to pay GPs for their time may elucidate if the group that declined are different. The interviews were conducted by recently qualified GPs (CCW, SN), and the interviewees were older, more experienced GPs. We hope that this may have led to freer expression (doctors 'speaking the same language') than if the interviews had been conducted by non-GPs; although conversely, the same profession talking to each other may make unconscious 'collusion' more likely. The fact that the interviewees were younger may have meant that the interviewees felt unthreatened and therefore more open.¹² The use of two interviewers who analysed their own interviews in detail was felt to increase the reliability of the method. This was further increased by analysis of part of the other interviewer's data and regular discussion of the overall analysis between the two interviewers and a social scientist (MG).

The management of minor mental illness in primary care

It has been suggested that minor mental health problems are not illnesses but essentially normal responses to social distress.¹³ Accordingly, it may be that minor mental illness is managed in a fundamentally different way to major mental illness or physical illness. Our study identified two types of referral: proactive, rational referrals to another person or agency, and reactive, emotive referrals away from the GP. For minor mental illness there was a tendency towards reactive reasons for referral. We suspect that, for major mental illness or for physical illness, proactive reasons for referral dominate, although separate work would need to be done to investigate this. Part of the reason for this fundamental difference between minor mental illness and physical or major mental illness may be that the latter makes much less of an impact on the doctor's own state of mind. We believe that this analysis of the emotional component to referral is of significance in today's climate of promoting use of clinical guidelines. Guidelines do not take into account the GP's emotional responses, yet we have found that these responses play a vital part in the management decisions of one of the most common class of problem that GPs deal with. This would suggest that the value of guidelines in the management of minor depression/anxiety is limited. We also identified the concept of GPs being either 'containers' or 'conduits' in this study. Although this is a simplification of referral behaviours, it may be a useful descriptive model to contribute towards explaining the large variation that we already know exists between GPs.⁴

References

1. Shepherd M, Cooper B, Brown AC, Kalton G. *Psychiatric illness in general practice*. 2nd edn. Oxford University Press, 1981.
2. Freeling P, Downey LJ, Malkin JC. *The presentation of depression: current approaches*. [Occasional Paper 36.] London: Royal College of General Practitioners, 1987.
3. Defeat Depression Campaign (nd). *Questions and answers*. Royal College of Psychiatrists, 1997.
4. Creed F, Gowriskumar J, Russell T, Kincey J. General practitioner

- referral rates to district psychiatry and psychology services. *Br J Gen Pract* 1990; **40**: 450-454.
5. Wilken D, Smith AG. Variation in general practitioners' referral rates to consultants. *Br J Gen Pract* 1987; **37**: 350-353.
 6. King N, Bailey J, Newton P. Analysing general practitioners' referral decisions. 1. Developing an analytical framework. *Fam Pract* 1994; **11**: 3-8.
 7. Pilgrim D, Rogers A, Clarke S, Clark W. Entering psychological treatment: decision-making factors for GPs and service users. *J Interprofess Care* 1997; **11**: 313-323.
 8. Patton MQ. *Qualitative evaluation and research methods*. 2nd edn. London: Sage, 1990.
 9. Glaser BG, Strauss AL. *The discovery of grounded theory: strategies for qualitative research* Chicago: Aldine, 1967.
 10. Ritchie J, Spencer L. Qualitative data analysis for applied policy research. In: Bryman A, Burgess RG (eds). *Analysing qualitative data*. London: Routledge, 1994; 173-194.
 11. Mays N, Pope C. Rigour and qualitative research. *BMJ* 1995; **311**: 109-112.
 12. Hoddinott P, Pill R. A review of recently published qualitative research in general practice. More methodological questions than answers? *Fam Pract* 1997; **14**: 313-319.
 13. Brown G. Depression: a sociological view. In: *Health and disease: a reader*. 2nd edn. Milton Keynes: Open University Press, 1995: chapter 23.

Acknowledgements

We are grateful to Dr Geoff Harding for his advice with planning and writing up, Ms Cash Davis for transcribing the tapes, and to the 23 general practitioners who gave their time without payment.

The costs of the study were paid for by the Claire Wand Fund of the BMA. SN was funded by the London Academic Training Scheme (LATS).